550

Health

Budget function 550 includes federal spending for health care services, disease prevention, consumer and occupational safety, health-related research, and similar activities. The largest component of spending is the federal/state Medicaid program, which funds health services for some low-income women, children, and elderly people as well as people with disabilities. Mandatory outlays for Medicaid increased by more than 10 percent per year in the early 1990s and have risen significantly again in the past few years. CBO estimates that in 2003, the federal government will spend $157 billion on Medicaid and a total of $216 billion on function 550. Discretionary outlays make up only about $43 billion of that total. They have grown every year since 1990.

Federal Spending, Fiscal Years 1990-2003 (In billions of dollars)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	Estimate 2003
Budget Authority (Discretionary)	16.1	18.2	19.6	20.7	22.2	22.8	23.3	25.1	26.4	30.2	33.8	38.9	45.8	44.7
Outlays														
Discretionary	14.9	16.2	18.0	19.6	20.5	22.0	22.6	23.0	24.9	26.9	30.0	33.2	39.4	43.3
Mandatory	42.9	55.0	71.5	79.8	86.6	93.4	96.8	100.9	106.6	114.1	124.5	139.1	157.1	173.1
Total	57.7	71.2	89.5	99.4	107.1	115.4	119.4	123.8	131.4	141.1	154.5	172.3	196.5	216.4
Memorandum: Annual Percentage Change in Discretionary Outlays	n.a.	8.8	11.1	9.3	4.6	7.2	2.5	1.7	8.2	8.4	11.4	10.5	18.8	9.9

Note: n.a. = not applicable.

550-01—Mandatory

Reduce the Enhanced Federal Matching Rates for Certain Administrative Functions in Medicaid

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	970	1,180	1,520	1,620	1,740	7,030	18,000

The federal government pays part of the costs that states incur in administering their Medicaid programs. The federal matching rate is 50 percent for most administrative activities but is higher in certain cases. For example, the federal government pays 75 percent of the costs of skilled medical professionals who are employed in Medicaid administration, 75 percent of the costs of utilization review, 90 percent of the costs of developing systems to process claims and manage information, and 75 percent of the costs of operating such systems.

This option would set the federal matching rate for all Medicaid administrative costs at 50 percent. That change would save $970 million in 2004 and $7.0 billion over five years.

Supporters of this option would argue that enhanced matching rates are designed to encourage states to develop and support particular administrative activities that the federal government considers important for the Medicaid program. Once the administrative systems are operational, however, there may be less reason to continue to pay higher rates. Moreover, because states pay about 43 percent of the cost of health care for Medicaid beneficiaries, on average, they have clear incentives to maintain efficient information systems and employ skilled professionals.

Opponents would counter that without higher matching rates, states might decide to cut back on some activities, with adverse consequences for the quality of care and for program management. For example, states might hire fewer nurses to conduct utilization reviews and oversee care in nursing homes, or they might make fewer improvements to their information-management systems. However, if the Congress wanted to support particular administrative functions, it could retain the higher matching rates for those functions while reducing the matching rates for others.

RELATED OPTIONS: 550-02 and 550-03

550-02—Mandatory

Restrict the Allocation of Common Administrative Costs to Medicaid

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	280	320	390	390	390	1,770	3,720

Public assistance programs have certain administrative tasks that are common to the enrollment process, such as collecting information about a family's income, assets, and demographic characteristics. Before the 1996 welfare reform law, the federal government's three major public assistance programs—Aid to Families with Dependent Children (AFDC), Food Stamps, and Medicaid—all reimbursed states for 50 percent of most types of administrative costs. As a matter of administrative convenience, states usually charged the common administrative costs of those programs to AFDC.

The welfare reform law replaced AFDC and some related programs with the Temporary Assistance for Needy Families (TANF) block-grant program. The block grants that states receive are based on past federal welfare spending, including reimbursements for administrative costs. Thus, insofar as states had previously paid the common administrative costs of public assistance programs from AFDC funds, those amounts are now included in their block grants. Although the welfare reform law was silent about the cost allocation process, the Department of Health and Human Services requires states to charge part of those common administrative costs to Medicaid, even if the costs are already included in the states' TANF block grants.

This option would reduce federal reimbursement for the administrative costs of Medicaid to reflect the share of those costs that is assumed to be covered by the TANF block grant; it would also prohibit states from using TANF funds to pay those costs. (Assuming that states spend all of their TANF block-grant funds in the long run, prohibiting them from using those funds to pay Medicaid administrative costs would increase the savings from this option in the early years, although it would have little effect over a longer period.) The reduction in funding would equal about one-third of the common costs of administering the Medicaid, AFDC, and Food Stamp programs that were charged to AFDC during the base period used for determining the amount of the TANF block grant. (A similar adjustment has already been made in the amount that the federal government pays the states to administer the Food Stamp program.)

The primary advantage of this option would be its savings: federal outlays would decline by $280 million in 2004 and by almost $1.8 billion over the 2004-2008 period. If the policy allowed states to use TANF funds to pay those administrative costs, the savings would be smaller in the short run: $150 million in 2004 and $1.7 billion over five years. In the long run, the savings would be about the same as under this option.

Critics of this option would argue that reducing federal reimbursements could hamper states' outreach activities to enroll more eligible children in Medicaid and the State Children's Health Insurance Program or could prompt states to reduce eligibility or services. As a result, fewer people might be enrolled in those programs.

RELATED OPTIONS: 550-01 and 550-03

550-03—Mandatory

Reduce Spending for Medicaid Administration

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	2,150	2,560	2,980	3,410	3,880	14,980	43,580

Option 550-02 describes one way to limit federal payments to the states for Medicaid's common administrative costs. An alternative strategy would be to base those payments on matching payments for administrative costs in the period before the Temporary Assistance for Needy Families (TANF) block-grant program was established. Under this option, the federal government would cap the amount per enrollee that it paid the states for Medicaid administration. That cap would grow by 5 percent a year from the base-year amount, which would be the administrative costs per enrollee for which the states claimed matching payments in 1996. Savings from that change would total almost $2.2 billion in 2004 and $15.0 billion over the 2004-2008 period.

Under this approach, states that had allocated Medicaid's common administrative costs to the Aid to Families with Dependent Children program before TANF's creation would not have those costs included in their projected Medicaid administrative costs. But states that had claimed those common costs through the Medicaid program would have them built into their administrative cost base for Medicaid. Limiting federal payments to a 5 percent growth rate would produce large savings because the actual growth rate of administrative costs averaged more than 5 percent a year during the 1996-2002 period and is projected to exceed 5 percent in 2003 and later years.

RELATED OPTIONS: 550-01 and 550-02

550-04—Mandatory

Convert Medicaid Payments for Acute Care Services into a Block Grant

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	3,170	6,380	11,940	17,860	24,680	64,030	318,070

The Medicaid program funds two broadly different types of health services for low-income people: acute care (including inpatient stays in hospitals, visits to physicians' offices, and prescription drugs) and long-term care (such as nursing home care and home- and community-based services). The program is financed jointly by the states and the federal government, with the government matching state spending at a rate of 50 percent to 83 percent depending on the state's per capita income. (The matching rate averages 57 percent nationwide.) Although the federal match helps states provide health coverage to disadvantaged populations, it may also encourage overspending by subsidizing each additional Medicaid dollar spent. In 2002, the federal share of Medicaid outlays amounted to $80.2 billion for acute care and $43.1 billion for long- term care.

This option would convert the federal share of Medicaid payments for acute care services into a block grant, as 1996 legislation did with welfare programs. (Long-term care would continue to be financed as it is now.) Each state's block grant would equal its 2003 federal Medicaid payment for acute care, indexed to the increase in the medical consumer price index for urban consumers. That change in financing would reduce federal outlays by $3.2 billion in 2004 and by $64.0 billion over the 2004-2008 period because federal Medicaid payments are projected to grow faster than that price index under current law. (Alternatively, block grants could be indexed to changes in a state's Medicaid caseload. In that case, savings would be the same in 2004 but would grow at a slower rate thereafter, totaling $55.6 billion over five years.) In exchange for slower growth in payments, states would be given more flexibility in how they could use the funds to meet the needs of their low-income and uninsured populations.

The Administration has proposed a Medicaid block-grant plan in its 2004 budget request. Its proposal would give states the option of operating under current Medicaid rules or choosing separate block grants for acute care and long-term care. Those grants would include funds for both Medicaid and the State Children's Health Insurance Program and would allow significantly more flexibility in program administration.

Supporters argue that subsidizing acute care with a block grant rather than a federal matching rate would give states more incentive to spend money cost-effectively by requiring them to face the full cost of each additional dollar of health spending. Block grants would also give states more discretion in designing and administering their own programs. For example, some states might choose to offer a less generous benefit package in order to extend coverage to more people. In addition, block grants would end states' incentives to employ funding strategies that are designed mainly to maximize federal assistance.

Opponents counter that converting acute care payments to a block grant would have various drawbacks. First, the block-grant option as described here would reduce the total amount of federal support for Medicaid, which could increase fiscal pressures on states. Second, removing the matching rate could provide an incentive for states to scale back their Medicaid coverage. Unless states were willing to do more themselves or could find ways to provide care more cost-effectively, some people who would benefit under current law might receive less coverage or none at all. Third, distinguishing between acute and long-term care for the purposes of financing could be difficult administratively. For example, hospital patients often receive services that resemble long-term care to facilitate their recovery after an inpatient stay. Fourth, having greater state discretion could widen the gaps that now exist between different states' Medicaid benefits and eligibility requirements.

550-05—Mandatory

Convert Medicaid Disproportionate Share Hospital Payments into a Block Grant

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	680	760	850	930	1,000	4,220	10,480

Hospitals that serve a disproportionately large share of low-income patients may receive higher payments from Medicaid than other hospitals do. Under broad federal guidelines, each state determines which hospitals receive so-called disproportionate share hospital (DSH) payments and the size of those payments. During the late 1980s and early 1990s, many states were able to increase the amount of federal Medicaid funding they received relative to the amount they spent on disproportionate share hospitals—in effect raising the federal matching rate above the rate specified in statute for a given state. To accomplish that, states assessed special taxes, accepted donations, or obtained intergovernmental transfers from DSH hospitals; made a DSH payment back to those providers, financed wholly or partly by the tax, donation, or transfer; reported the DSH payment to Medicaid; and subsequently obtained federal matching payments for those funds.

During the 1990s, lawmakers enacted a series of restrictions on Medicaid DSH payments, culminating in fixed ceilings on states' DSH payments that applied through 2002. After 2002, those ceilings are adjusted to keep pace with inflation. Consequently, federal outlays for Medicaid DSH payments, which totaled $8.7 billion in 2002, are projected to rise to $9.5 billion by 2008 under current law.

This option would convert the current Medicaid disproportionate share hospital program into a block grant to the states, as an alternative way to provide federal financial support for health care institutions that serve a large share of poor and uninsured patients. The grant could be reduced below current-law levels and its future growth limited to a slower rate than the rate at which Medicaid DSH payments would increase under current law. In exchange for lower funding, states could be given greater flexibility to use the funds to meet the needs of their low-income and uninsured populations in the most cost-effective ways.

In this illustrative option, the block grant for each state in 2004 would equal the state's Medicaid DSH allotment for 2003 minus 10 percent. In subsequent years, the block grant would be indexed to the increase in the consumer price index for urban consumers minus 1 percentage point. Savings from this option would total $680 million next year and $4.2 billion over the 2004-2008 period.

Supporters of a block grant would argue that the increased latitude provided to states under this option could result in DSH funds' being targeted more appropriately and equitably to facilities and providers that serve low-income populations. For example, states would have greater flexibility to use those funds to support outpatient clinics and other nonhospital providers that treat Medicaid beneficiaries and low-income patients.

Opponents of this option would argue that given the fiscal problems facing many states today, state governments might not increase their contributions to make up for the reduction in federal subsidies. As a result, hospitals (and health care providers in general) could receive less in combined federal and state Medicaid subsidies. Additionally, giving states more flexibility to allocate DSH payments could alter the distribution and amount of assistance among hospitals, possibly causing some large urban hospitals to receive less public funding than they do now. Moreover, states may already have enough flexibility under current rules to allocate DSH payments to achieve the maximum benefit.

RELATED OPTIONS: 550-06 and 570-05

550-06—Mandatory

Require All States to Comply with New Rules About Medicaid's Upper Payment Limit by 2004

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	2,770	1,940	1,170	890	560	7,330	7,330

Until 2001, federal regulations stated that Medicaid could not pay more for hospital and nursing home services than the Medicare program did. That ceiling, known as the upper payment limit (UPL), applied to aggregate payments for services provided in both private facilities and those operated by local governments. Since Medicaid's payment rates are typically lower than Medicare's, most states had room to increase their Medicaid payments without exceeding the UPL. As a result, many states inflated their payment rates for services provided in local government facilities so as to generate additional federal matching funds and then recovered the inflated portion of those payments from the facilities. The additional federal Medicaid funds could then be used for any purpose. That process effectively increased federal Medicaid payments to states without raising the states' Medicaid expenditures.

To limit states' ability to generate enhanced payments, the Department of Health and Human Services issued regulations in January 2001 that created separate UPLs for private facilities and facilities operated by local governments. Those regulations (as required by the Benefits Improvement and Protection Act of 2000) take full effect at different times for different states. States that have used the enhanced-funding mechanism the longest are allowed a transition period stretching to September 30, 2008, whereas some other states have a transition period lasting until 2005. (States that had only recently sought to enhance their funding are already subject to the new rules.) The extended transition period was designed to give states with the longest history of relying on enhanced payments more time to adjust their budgets to the smaller federal payments that result from the new regulations.

This option would require all states to be in full compliance with the UPL regulations beginning in 2004. That requirement would reduce federal outlays by almost $2.8 billion in 2004 and $7.3 billion over five years.

Supporters of this option argue that eliminating the extended transition period would treat all states the same, which is more equitable than allowing some states to continue, in effect, to obtain a higher federal matching rate than the one specified by statute. Opponents counter that requiring quicker compliance would reduce federal payments to some states at a time when they are already facing severe budgetary difficulties.

RELATED OPTIONS: 550-05 and 570-05

550-07—Mandatory

Reform the Process for Listing Drug Patents in the FDA's Orange Book

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	10	30	80	180	300	590	4,410

Many top-selling brand-name drugs are protected by multiple patents. Those patents can cover a drug's substance (chemical compound), its use, or its formulation (such as an extended-release dosage), as approved by the Food and Drug Administration (FDA). Such patents are listed in an FDA volume titled *Approved Drug Products with Therapeutic Equivalence Evaluations*, commonly known as the Orange Book. A manufacturer wishing to market a generic version of a brand-name drug must either formally challenge a patent listed in the Orange Book or wait until the patent expires before the FDA can approve its application to produce a generic copy.

Although the FDA publishes patent information in the Orange Book, it makes no judgments about whether the patent submitted by a brand-name manufacturer actually covers the drug in question. As a result, some of the patents currently included in the Orange Book may be inappropriately listed, in that they do not claim the same use, formulation, or drug substance that the FDA approved. (A single drug patent can make several claims.)

This option would require that for each patent listed in the Orange Book, the brand-name manufacturer would identify those claims that met the FDA's listing criteria and specify whether the claim related to the approved substance, use, or formulation of the drug. The FDA would publish that direct mapping of patent claims, by type of claim, in the Orange Book. Manufacturers of generic drugs could petition the Secretary of Health and Human Services to review specific listings on an expedited basis. If the Secretary found that a patent or claim did not appear to cover the approved substance, use, or formulation, the Secretary could request that the brand-name company delist the patent or claim. Under this option, any manufacturer interested in producing a generic copy would also be able to sue that brand-name company over the appropriateness of the patent listing. Those changes would apply to both current and future patent listings.

By helping to ensure that the information in the Orange Book was clear and accurate, this option could speed the marketing of generic drugs in some cases. Generic drugs have much lower prices than their brand-name counterparts; consequently, the Congressional Budget Office estimates that federal direct spending on drugs by Medicaid, the Federal Employees Health Benefits Program, the Department of Defense, and (to a limited extent) Medicare would decline by an average of 1 percent over 10 years. As a result, federal outlays would fall by $590 million over five years and $4.4 billion over 10 years.

The FDA has proposed a rule that would require manufacturers to submit patent information on a claim-by-claim basis, as discussed in this option. That proposed rule would be limited to patents not yet listed in the Orange Book.

Under this option, some brand-name drugs would be likely to experience competition from multiple generic copies earlier than they would under current law. Not only the federal government but also states and private-sector purchasers would benefit from the lower average drug prices associated with earlier marketing of generic drugs.

However, to the extent that brand-name manufacturers' sales declined under this option, they would have less money available and less incentive to invest in developing new drugs. The effect on that incentive would probably be small, however, because any decline in profits would occur toward the end of a drug's market life and would thus be heavily discounted (in present-value terms) when the decision about investing in research and development was made.

RELATED OPTION: 550-08

550-08—Mandatory

Eliminate the 30-Month Stay for Late-Listed Patents

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	2	7	18	31	46	104	719

The 1984 Drug Price Competition and Patent Term Restoration Act (also known as the Hatch-Waxman Act) created a process whereby manufacturers of generic drugs can challenge patents on brand-name drugs. Many top-selling brand-name drugs are protected by multiple patents, which can cover the substance, use, or formulation of the drug as approved by the Food and Drug Administration (FDA). Such patents, together with the brand-name products that they cover, are published by the FDA (see option 550-07). If a generic manufacturer can successfully demonstrate that a patent is invalid or would not be infringed by its generic copy, it can enter the market before the patent on the brand-name drug expires. Some observers believe that the patent-challenge process established under the Hatch-Waxman Act has encountered unanticipated delays that have lessened competition by slowing the marketing of generic drugs in some cases.

Generic manufacturers apply to the FDA for approval to produce a bioequivalent copy of a brand-name drug by filing an abbreviated new-drug application (ANDA). When doing so, they must inform the FDA and the brand-name manufacturer of any patents that they are challenging. If the brand-name manufacturer does not sue to defend its patent within 45 days of receiving notification, the FDA can approve the generic company's ANDA as soon as the company has successfully demonstrated bioequivalence. If, however, the brand-name manufacturer does sue, the FDA cannot approve the generic company's ANDA for 30 months or until a district court rules in favor of the generic company. That delay is referred to as a 30-month stay. When the brand-name company wins such a suit, the FDA cannot approve the ANDA until the challenged patent has expired. Conversely, when a generic manufacturer that is the first to file an ANDA with a patent challenge obtains FDA approval and is able to enter the market before the challenged patent expires, it may be eligible for 180 days of marketing exclusivity. (That exclusivity period gives generic manufacturers an incentive to take on the litigation costs associated with challenging a patent.)

One event that can slow down the patent-challenge process is to have a new patent issued on a brand-name drug after a generic manufacturer has already filed its ANDA. A report by the Federal Trade Commission (FTC) found several recent cases in which a patent was listed after an ANDA had been filed, resulting in a new 30-month stay. Such patents are latecomers to the patent-challenge process and can prolong litigation.

Under this option, patents listed for a brand-name drug after an ANDA had already been filed would no longer be entitled to a 30-month stay. Instead, if a generic applicant challenged the late-listed patent, the brand-name manufacturer would be required to sue within 45 days and obtain a preliminary injunction to place a stay on FDA approval. If no preliminary injunction was granted by the court, the late-listed patent would not hold up the FDA's final approval of the challenger's ANDA. Further, if the brand-name manufacturer did not sue within 45 days of being notified of the challenge to its late-listed patent, it would lose the right to sue the challenger in the future for infringement of the patent.

Together, those changes would help bring some generic drugs to market more quickly, thus reducing the average price of certain drugs. The Congressional Budget Office estimates that federal direct spending on drugs by Medicaid, the Federal Employees Health Benefits Program, the Department of Defense, and (to a limited extent) Medicare would decline, saving $104 million over the 2004-

2008 period. Nongovernment purchasers would also benefit from the lower average cost of drugs that experienced earlier competition from generic copies.

The FDA has proposed a rule that would allow only one 30-month stay per ANDA. That rule, which has not taken effect, is somewhat less comprehensive than this option. Whereas this option would require legislative action, the proposed rule would rely on the FDA's reinterpretation of the Hatch-Waxman Act.

Besides 30-month stays on late-listed patents, another mechanism that can delay the marketing of a generic drug is an agreement to that effect reached by the brand-name and generic manufacturers before a court ruling. Moreover, in that case, subsequent generic applicants may be unable to obtain FDA approval while the agreement is in effect (because of interactions with the 180-day marketing exclusivity). Requiring that such agreements be reported to the FTC could help reduce their frequency and facilitate earlier marketing of some generic drugs. However, that requirement would produce relatively small savings in the federal government's drug spending, in part because the FTC has already increased its oversight of such agreements.

To the extent that sales of brand-name drugs declined under this option, both the incentive to invest in the development of new drugs and the profits available for reinvestment would be lessened.

RELATED OPTION: 550-07

550-09—Discretionary

Reduce Subsidies for Health Professions Education

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Savings							
Budget authority	195	200	200	205	210	1,010	2,140
Outlays	70	150	185	200	205	810	1,910

In 2002, lawmakers provided $180 million to the Public Health Service to subsidize institutions that educate physicians and other health professionals. Those subsidies primarily take the form of grants and contracts to schools and hospitals. Several programs provide federal grants to medical schools, teaching hospitals, and other training centers to develop, expand, or improve graduate medical education in primary care specialties and related health fields and to encourage health professionals to practice in underserved areas.

This option would eliminate those grants and subsidies, saving $70 million in outlays next year and $810 million over the 2004-2008 period.

Supporters of this option argue that even without those subsidies, market forces provide strong incentives for people to seek training and jobs in the health professions, so federal subsidies are unnecessary. Over the past several decades, the number of physicians—one of the health professions targeted by the subsidies—has increased rapidly. In 2000, for example, the United States had 288 physicians in all fields for every 100,000 people, compared with just 142 in 1960.

Critics counter that market incentives may not be strong enough by themselves to achieve desired levels of health professionals. For instance, third-party reimbursement rates for primary care may not encourage enough physicians to enter those specialties and may not provide sufficient financial inducements to increase access to care in underserved areas.

RELATED OPTIONS: 570-01, 570-02, 570-03, and 570-04

550-10—Mandatory

Finance the Food Safety Inspection Service Through User Fees

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Outlay Savings	350	720	750	780	800	3,400	7,900

The Food Safety and Inspection Service (FSIS), an agency in the Department of Agriculture, regulates the safety and proper labeling of most domestic and imported meat and poultry sold for human consumption in the United States. It also ensures the safety of certain egg products. The FSIS employs about 10,000 inspectors, one or more of whom must be present at all times when a meat or poultry slaughtering plant is operating. In addition, inspectors monitor processing plants daily for adherence to federal standards (for sanitary conditions, ingredient levels, and packaging) and sample and test processed meat and poultry products. Recently, the FSIS has also been charged with protecting the nation's meat and poultry products from bioterrorism. The agency gets most of its funding through annual appropriations—which totaled $731 million in 2002—but the meat packing industry pays for FSIS inspectors (through user fees) when its plants are operating on holiday or overtime hours.

This option would finance all federal meat and poultry inspection activities (in addition to those that occur on holiday or overtime shifts) through user fees paid by meat and poultry slaughtering and processing firms. That change would reduce federal outlays by $350 million in 2004 and by a total of $3.4 billion over five years.

Proponents of this option argue that users of government services should pay for those services. Federal inspections benefit both producers and consumers of meat and poultry products because they prevent diseased animals from being sold as food. But the meat and poultry industries benefit in other ways as well: for example, they can advertise their products as having been inspected by the Department of Agriculture, which may enhance the quality of those products in the eyes of consumers.

Opponents of this option maintain that the current system of public financing is appropriate because the public at large benefits from meat and poultry inspections, since the inspections may prevent the transmission of infectious diseases from those animals to other food or water sources. Moreover, if the packing industry was required to pay user fees, consumers would probably face higher prices for meat and poultry products.

550-11—Discretionary and Mandatory

Adopt a Voucher Plan for the Federal Employees Health Benefits Program

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Savings[a]							
Discretionary[b]	400	900	1,300	1,700	2,200	6,500	25,000
Mandatory	300	800	1,200	1,600	2,100	6,000	24,500

a. Estimates do not include any savings realized by the U.S. Postal Service.

b. Savings measured from the 2003 funding level adjusted for premium increases and changes in employment.

The Federal Employees Health Benefits (FEHB) program provides health insurance coverage for more than 4 million federal employees and annuitants, as well as for their 4.6 million dependents and survivors, at an expected cost to the government of almost $18.5 billion in 2003. The cost-sharing structure of the FEHB program encourages federal employees to switch from high-cost to lower-cost plans to blunt the effects of rising premiums; cost sharing also intensifies competitive pressures on all participating plans to hold down premiums. The federal government's share of premiums for employees and annuitants (including for family coverage) is 72 percent of the average weighted premium of all plans. (The employer's costs are higher for the U.S. Postal Service under that agency's collective bargaining agreement.) Policyholders are required to pay at least 25 percent of the premium of any particular plan. (Since October 1, 2000, employees' premiums have come out of pretax income, consistent with the practice for workers in the private sector.)

This option would reduce federal expenditures by offering a flat voucher for health insurance that would cover the first $2,800 of premiums for individual employees and retirees or $6,300 for family coverage. Those amounts, which are based on the government's average expected contribution for nonpostal employees in 2003, would increase annually at the rate of inflation rather than at the average weighted rate of change for premiums in the FEHB program. Indexing premiums to inflation rather than to the growth of premiums would produce budgetary savings because the Congressional Budget Office expects FEHB premiums to grow more than twice as fast as inflation under current law. Savings in discretionary spending (from lower payments for current employees and their dependents) would be $400 million in 2004 and a total of $6.5 billion over five years. Savings in mandatory spending (from reduced payments for retirees) would be $300 million in 2004 and $6.0 billion over five years.

Supporters of this option contend that it would strengthen price competition among health plans in the FEHB program because nearly all current enrollees would be faced with paying the full amount of premiums above the level of the voucher. In addition, removing the requirement that enrollees pay at least 25 percent of their premiums should increase price competition among low-cost plans to attract participants. In the lowest-cost plans, the government voucher would cover almost the entire premium.

Opponents of this option point out that participants would pay an ever-increasing share of their premiums—possibly more than 40 percent by 2008—if premiums rose as expected. The added cost to enrollees could exceed $1,300 per worker in 2008 and more in later years. Currently, large private-sector companies' health plans provide better benefits for employees—although not for retirees—which makes it harder for the government to attract high-quality workers. In addition, opponents note that for current federal retirees and long-time workers, this option would cut benefits that have already been earned. Finally, the option could strengthen existing incentives for plans to structure benefits to disproportionately attract people with lower-than-average health care costs. That "adverse selection" could destabilize other health care plans.

RELATED OPTION: 550-12

RELATED CBO PUBLICATION: *Comparing Federal Employee Benefits with Those in the Private Sector*, August 1998

550-12—Mandatory

Base Retirees' Health Benefits on Length of Federal Service

(Millions of dollars)	2004	2005	2006	2007	2008	Total 2004-2008	Total 2004-2013
Savings[a]							
Budget authority	80	170	270	380	510	1,410	6,390
Outlays	80	170	270	380	510	1,410	6,390

a. Estimates do not include any savings realized by the U.S. Postal Service.

Federal retirees are generally eligible to continue receiving benefits from the Federal Employees Health Benefits (FEHB) program if they have participated in the program during their last five years of service and are eligible to receive an immediate annuity. About 78 percent of those new retirees elect to receive health benefits. For retirees over age 65, the FEHB program's benefits are coordinated with those of Medicare; the program pays amounts not covered by Medicare (but no more than what it would have paid in the absence of Medicare). Participants and the government share the cost of premiums. The government's share for annuitants and employees is 72 percent of the weighted average premium of all participating plans (up to a cap of 75 percent of the total premium). In 2003, the government expects to pay $6.6 billion in premiums for 1.4 million nonpostal annuitants plus their dependents and survivors.

This option would reduce health benefits for retirees with relatively short federal careers, although it would preserve their right to participate in the FEHB program. For new retirees only, the government's share of premiums would be cut by 2 percentage points for every year of service less than 30. For example, for a retiree with 20 years of service, the government's contribution would fall from 70 percent to 50 percent of the average premium. (On average, the government pays a lower share of premiums for annuitants than employees because annuitants tend to enroll in more expensive plans.) In 2002, about 60 percent of the roughly 87,000 new retirees who continued in the FEHB program had less than 30 years of service. The average new retiree affected by this option would pay 40 percent of the premium rather than 28 percent, an annual increase of $700 in 2004. The estimated savings to the government in mandatory spending would total $80 million in 2004 and $1.4 billion over five years. (Those estimates exclude savings realized by the Postal Service.)

Proponents of this option contend that it would make the government's mix of compensation fairer and more efficient by improving the link between length of service and deferred compensation. It would also help bring federal benefits closer to those of private firms. Federal retirees' health benefits are significantly greater than those offered by most large private firms, which have been aggressively paring and, in some cases (about 20 percent), eliminating retirees' health benefits for new hires in recent years. A survey of medium and large U.S. employers found that just over 40 percent provide medical benefits to retirees. Moreover, of those companies still offering such benefits, most have tightened eligibility rules for new hires (typically requiring 10 or more years of service), implemented service-related contributions for future retirees, and capped contributions for new hires, according to a 2001 survey by Watson Wyatt, a benefits consulting firm.

Opponents of this option assert that it would mean a substantial cut in promised benefits, the effects of which would be felt most strongly by the roughly 25 percent of new retirees with less than 20 years of service. The option could also encourage some employees with short federal careers to delay retirement, whereas others might accelerate retirement plans to avoid the new rules.

RELATED OPTION: 550-11

RELATED CBO PUBLICATION: *Comparing Federal Employee Benefits with Those in the Private Sector*, August 1998